



200 Theda Clark Medical Plaza, Suite 130
Neenah, WI 54956
(920) 729-7105 or (877) 729-7105 toll free
www.womenscareofwi.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names

Birth Date

Street Address

City, State, Zip Code

AUTHORIZES:

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Women's Care of Wisconsin
200 Theda Clark Medical Plaza, Suite 130
Neenah, WI 54956

Name/Organization

Street Address

City, State, Zip Code

- All WCOW records one time at no charge
- Subsequent copies will be \$0.35 per page

<u>Information to be released:</u>	<u>Date of Service</u>		<u>Date of Service</u>
<input type="checkbox"/> Progress Notes	_____	<input type="checkbox"/> Discharge Summary	_____
<input type="checkbox"/> Ultrasound	_____	<input type="checkbox"/> Operative/Procedure Report	_____
<input type="checkbox"/> OB/ACOG	_____	<input type="checkbox"/> Physical Therapy	_____
<input type="checkbox"/> History and Physical	_____	<input type="checkbox"/> Labs	_____
<input type="checkbox"/> Pathology/Lab Report	_____	<input type="checkbox"/> X-ray/EKG/Ultrasound	_____
<input type="checkbox"/> Consultations	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Immunizations	_____		

In compliance with Wisconsin Statutes that require special permission to release otherwise privileged information, please release records pertaining to:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol Abuse or test results | <input type="checkbox"/> HIV test results, AIDS or AIDS-Related disease |
| <input type="checkbox"/> Drug Abuse or test results | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Mental Health | |

This disclosure is being made for the following purpose(s):

- | | |
|--|---|
| <input type="checkbox"/> Further medical Care | <input type="checkbox"/> Work Comp |
| <input type="checkbox"/> Relocation/Moving | <input type="checkbox"/> Attorney/Court Case |
| <input type="checkbox"/> Insurance Change | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> At the request of an individual | <input type="checkbox"/> Other (comments) _____ |
| <input type="checkbox"/> Changing Physicians (explain) _____ | |

Right to Inspect or Copy the Information to be Used or Disclosed

I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact WCOW's Compliance Officer.

Right to Receive a Copy of this Authorization

I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

Redisclosure of Information by Recipient

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact WCOW's Compliance Officer at:

200 Theda Clark Medical Plaza, Suite 130
Neenah, WI 54956
Phone: (920) 729-7105
Toll Free: (877) 729-7105
Fax: (920) 720-2150

Right to Revoke Authorization

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to WCOW. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if WCOW uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

Prohibition of Conditions

WCOW may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Signature of patient

Date

Signature of personal representative, person authorized by the patient, or legal authority

Relationship or legal authority

Medical Records Policy

Women's Care of Wisconsin will supply you with one copy of your medical records at no cost to you. If you would like to obtain a second copy of records the service fee will be \$0.35 per page. Please allow approximately 2 weeks for your medical records to be mailed to the requested party. In case of an emergent request, please speak with the medical records clerk in the Neenah location of Women's Care of Wisconsin.

Office Use Only:
Records completed on _____
Initials _____

Exceptions or other notes regarding records:

